

Please fax completed applications to
(918) 627 - 4111

MedSupport, LLC

Employment Application

Position Applied For _____ Full Time _____ Part Time				Today's Date	
Last Name		First Name		Middle Name	
Address		Street		City State Zip Code	
Telephone Number(s) () -			Social Security Number - -		

Are You over 18 Years of Age? _____ YES _____ NO
 Are You Eligible to Work in the United States? _____ YES _____ NO
 Have You ever been employed by MedSupport before? _____ YES _____ NO
 Do You have a valid driver's license? _____ YES _____ NO
 Do You have reliable transportation? _____ YES _____ NO
 Do You have liability car insurance? _____ YES _____ NO
 Have You ever been convicted of, or plead guilty to, a felony and/or a misdemeanor?
 _____ NO _____ YES (Please Explain) _____

Are You aware of any reason that you cannot perform essential functions of the job you are applying for with or without reasonable accomodation? _____ NO _____ YES (Explain) _____

Work History (Please start with your present or last job and list at least 2 years including gaps and volunteer work)

Employer		Address		Telephone Number	
Job Title	Supervisor	Dates Employed From: To:	Reason For Leaving		
Employer		Address		Telephone Number	
Job Title	Supervisor	Dates Employed From: To:	Reason For Leaving		
Employer		Address		Telephone Number	
Job Title	Supervisor	Dates Employed From: To:	Reason For Leaving		

References (Please list the names and telephone numbers of 3 work references who are not related to you)

Name	Telephone Number	Years Known

RELEASE AUTHORIZATION

In conjunction with my application for employment with MedSupport, LLC, I understand that an investigative consumer report may be requested as part of the application process and at any time during my employment with MedSupport, LLC, that will include information as to my character, work habits, performance and experience, along with reasons for termination of past employment from previous employers. I further understand that you will be requesting information concerning any worker's compensation claims, education, motor vehicle operation and criminal history from various state, private and insurance sources along with other public records available. Worker's compensation information will only be requested in compliance with ADA and/or any other applicable state laws.

I release from all liability and hold harmless all persons furnishing this information to MedSupport, LLC, I acknowledge that a telephonic facsimile (FAX) or photographic copy of all such information shall be as valid as the original copy. This release includes all state and federal agencies, including states' Department of Labor. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency. If so, I will be advised and given the name of the agency or source of information.

I HEREBY AUTHORIZE, WITHOUT RESERVATION, ANY LAW ENFORCEMENT AGENCY, ADMINISTRATOR, STATE AGENCY, INSTITUTION, INFORMATION SERVICE BUREAU, EMPLOYER, OR INSURANCE COMPANY CONTACTED BY MEDSUPPORT, LLC, TO FURNISH THE ABOVE-MENTIONED INFORMATION.

The following must be filled out completely for your application to be considered.

Name: _____
 Last First Middle Maiden

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security No: _____ Date of Birth: _____

Driver's License No: _____ State Driver's License Issued: _____

Signature of Applicant: _____ Date: _____